NavMed 369 RESTRICTED

NAVY DEPARTMENT

BUMED NEWS LETTER

a digest of timely information

Editor - Captain F. W. Farrar. (MC). U.S.N.

Vol. 8 Friday, August 2, 1946 No. 3

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Circular Letters:

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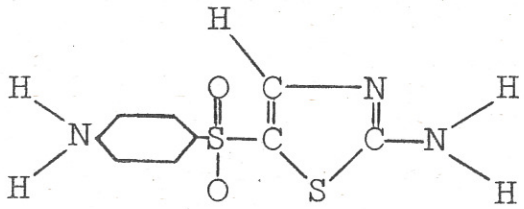
Promizole in the Treatment of Leprosy: Promizole is the trade name for 2,4'-diamino-5-thiasolylphenyl sulfone, which has the following structure:



It was synthesized primarily for the treatment of mycobacterial diseases, since promin had been found too toxic for continuous oral administration in these diseases. In preliminary experimental and clinical tuberculosis, promizole did not produce sufficiently encouraging results to warrant further investigation; however, good results were obtained in tuberculosis of the skin. For this reason and because of its relative nontoxicity by mouth and its close resemblance to promin and diasone, which had been used with some success in the treatment of leprosy, it was considered feasible to test the possible therapeutic effect of promizole on leprosy at the National Leprosarium, Carville, Louisiana. The present preliminary report is published because clinical improvement in patients under treatment for leprosy seems to appear in some cases more rapidly with promizole than with either promin or diasone. Past experiments with other sulfa drugs given orally, particularly sulfanilamide, have proved unsuccessful at the National Leprosarium.

At present 7 of the original group of 11 patients have been under treatment with promizole for approximately one year. These patients were started on doses of 0.5 Gm. three times daily, dosage being gradually increased to 2 Gm. three times daily, over a period of several weeks. All of these patients have tolerated the drug well.

In 2 of the original 11 patients it was necessary to discontinue the drug because of toxic reactions - general malaise in one patient, and repeated febrile episodes in the other. Discontinuance of medication in the other 2 patients was not incidental to the drug; one absconded from the institution, and the other died of a cerebrovascular accident.

After 6 months of treatment, objective clinical improvement was observed in some of the patients. Because of these encouraging results, 8 more patients were started on the promizole treatment, and some of them have already shown benefits. This makes a total of 15 under treatment at the present time, and others will be added when more of the drug becomes available.

No claim is made in regard to the ultimate value of promizole given orally in doses of 6 Gm. daily in the treatment of leprosy. However, it is felt that the

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therapeutic results thus far obtained are sufficiently encouraging to warrant further clinical study, which will be necessary before a final evaluation of promizole in the treatment of leprosy can be given. (Pub. Health Rep., June 28, '46 - Faget et al.)

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Present Status of Diasone in the Treatment of Leprosy: The clinical improvement of patients suffering from leprosy when treated with diasone (disodium formaldehyde sulfoxylate diamino diphenyl sulfone (Abbott)) is well known. The purpose of this present brief clinical note is to summarize the status of 104 patients treated at the National Leprosarium, Carville, Louisiana, with 17,200 Gm. of diasone over the past two and one-half years. In all cases the drug has been used by mouth in daily doses varying for adults from 0.33 Gm. to 1.00 Gm. and for children from 0.17 Gm. to 0.5 Gm. The drug has an advantage over the other sulfone drug, promin, which is being used in the largest number of patients at the National Leprosarium, in that diasone is well tolerated by mouth by most patients, whereas promin usually has to be given intravenously because of its toxicity by mouth.

At the present time, 66 of the 104 patients (63.5 per cent) have received treatment with diasone for 6 months or longer. Of these 66 patients, the lesions in 74.2 per cent were predominantly lepromatous, in 20.4 per cent, they were frankly mixed in type, and in only 5.4 per cent were neural. In 30 per cent leprosy was far advanced; in 51 per cent, it was moderately advanced; and in 19 per cent, the lesions were minimal in character.

At the present time, in 24 per cent of the diasone-treated patients, skin scrapings are bacteriologically negative for Mycobacterium leprae. This percentage compares favorably with the highly encouraging results that have been reported from the use of promin intravenously.

There is objective improvement in the specific leprous lesions (nodules and diffuse infiltrations) in 65 per cent of the patients who have been treated for 6 months and longer. In another 12 per cent, improvement is limited to changes in various nonspecific infections which appear to be favorably influenced by diasone therapy. In the remaining 23 per cent, the improvement is largely subjective, and no demonstrable change is claimed. There are no cases that are clinically worse.

Of the group of 104 patients, 7 (6.7 per cent) have received diasone for less than 6 months. No comments are made on their clinical condition, since a period of 6 months appears to be the time needed for changes in the leprous lesions to become manifest under diasone treatment.

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The remaining 31 patients (29.8 per cent) of the 104 have discontinued diasone treatment for the following reasons:

	Per cent
Absconded from the institution (6 cases)	5.76
Increased erythema nodosum, with fever (5 cases)	4.81
Eczematoid dermatitis (5 cases)	4.81
Gastric intolerance (5 cases)	4.81
Hematuria (4 cases)	3.85
Anemia (2 cases)	1.92
Iridocyclitis (2 cases)	1.92
Drug fever (1 case)	0.96
Hypertension (1 case)	0.96
Total	29.8

It would appear from clinical observations that diasone has an action similar to that of promin. Treatment with diasone has the advantage that the drug is tolerated by mouth in doses up to 1.0 Gm. daily for long periods of time. The number of patients in whom treatment was discontinued because of anemia is low, because many of the patients receive liver or iron products with the diasone. The number in whom treatment was discontinued because of hematuria is limited to four patients who were started with doses of 1.0 Gm. daily early in the study. At the present time diasone is administered in doses of 0.33 Gm. daily for the first 2 weeks and then gradually increased to 1.0 Gm. Since the adoption of this policy, there have been no further cases of hematuria.

The authors conclude that diasone, a derivative of diamino diphenyl sulfone, is suitable for oral administration in the treatment of leprosy. Patients with leprosy usually improve clinically within the first 6 months of treatment with diasone. (Pub. Health Rep., June 28, '46 - Faget et al.)

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The Treatment of Seasonal and Nonseasonal Hyperesthetic Rhinitis with Anthallan: The name "Hyperesthetic Rhinitis" was chosen by the author to designate the chronic hypersensitive nose experienced in common by patients often listed as cases of "nonseasonal hay fever," "physical allergy," "allergic rhinitis," "nasal allergy," "intrinsic allergy," "chronic rhinitis," and "vasomotor rhinitis." These patients experience sneezing, watery nasal discharge, itching of the nose or eyes, and intermittent nasal obstruction. Upon inspection of the nose, an increase in secretion, and an increase in thickness with change in color of the mucous membranes are seen. The nasal secretions contain an

excessive number of eosinophiles and an absence of bacteria. Transillumination, roentgenograms, and lavage of the sinuses show absence of infection.

Anthallan is 3'di(n-butyl)amino-methyl 1,4,5,6-trihydroxy-benzo(1,2,-c)-furan-1'(3')-one. It was developed by the Research Division of the Medico Chemical Corporation of America, New York City. Toxicological data submitted with the drug indicate a low toxicity. The drug is administered in amounts of 0.085 grams in capsules by mouth. The usual dosage required is 6 capsules daily during the first week of treatment; the dosage during subsequent weeks may vary between 3 and 12 capsules daily according to clinical response. The dosage does not have to be varied to any degree according to the age or sex of the patient.

The impressive results obtained from the treatment with anthallan in 108 cases of seasonal and nonseasonal hyperesthetic rhinitis by the author in private practice, and also the success reported elsewhere in the treatment of neurodermatitis disseminata and urticaria with anthallan prompted this report.

The criteria for selecting the cases in this study and for appraising the results from treatment were critically chosen and applied.

When anthallan treatment was started, the 42 patients concerned in this study had suffered from their disease continuously for periods of time of from 11 days to 5 years and averaging 506 days. These patients had shown relief of only short duration in response to the customary methods of treatment given to them before they were treated with anthallan. A beneficial influence from treatment with anthallan was observed from 40 out of 44 courses administered. The improvement varied from 25 per cent to 100 per cent subjectively and objectively. Treatment in which the estimate of improvement was not greater than 24 per cent was considered a failure. Four cases fell in this group. The patients experiencing complete or practically complete relief from symptoms numbered about 36 per cent during the course of therapy. An improvement of 70 per cent or more occurred in 56 per cent of the patients at the end of anthallan treatment. Only about 30 per cent of all cases showed any tendency to relapse after two post-treatment examination periods of one month or more, and in these cases a considerable degree of improvement was still retained. The persistence of the improvement recorded at the completion of treatment with anthallan was observed over an average of 50 days (minimum 7 days, maximum 248 days). Laboratory and clinical studies, carried out to determine the production of side reactions, did not indicate any harmful effects resulting from treatment with anthallan.

The author concludes that the results of his study show that anthallan used in dosages of from 3 to 12 capsules daily over a period of from 7 to 35 days by

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patients selected in accordance with the diagnostic criteria suggested is a useful drug for obtaining relief in a high percentage of cases of seasonal and nonseasonal hyperesthetic rhinitis, and that the drug can be used with complete safety. (Bull. New York Acad. Med., June '46 - A. D. Ghiselin, Jr.)

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Caution Against Production of Gangrene in Treatment with Ergotamine Tartrate: Ergotamine tartrate is the tartrate of an alkaloid obtained from ergot and is represented chemically by the empiric formula $(C_{33}H_{35}N_5O_5)_2.H_2C_4H_4O_6$. Francis R. Kenney describes a case of gangrene of the hands following treatment of pruritis (of hepatotoxic origin) by ergotamine tartrate (Gynergen). He reviews certain other reports in the literature covering similar serious complications and even death from the use of ergotamine tartrate.

In instituting treatment for severe pruritis, the therapeutic agent should be selected carefully with respect to its possible toxic effects, and consideration be given the fact that the poorer the general systemic condition of the patient, the greater is the danger of toxic reactions from drugs used to control pruritis.

Ergotamine tartrate is definitely useful as an antipruritic agent, but the potentialities for seriously detrimental reactions from its use must be considered.

When ergotamine tartrate is used as an antipruritic, the following precautions seem indicated. The dosage should not exceed 1 mg. administered three times a day orally. At least once daily, (but preferably twice) the patient should be questioned and examined concerning the presence in the extremities of any of the following: pain, coldness, cyanosis, loss of arterial pulsations, imparied sensation, and tingling. If any of these signs or symptoms occur, the drug should be discontinued and appropriate therapy to restore adequate blood supply to the parts involved should be started immediately.

The following are included among measures that may be effective in the treatment of poisoning from the use of ergotamine tartrate: papaverine hydrochloride (0.02-0.03 Gm.) administered intravenously or orally or both; ephedrine (24 mg.), orally; alcohol (15 c.c. every four hours), orally; magnesium sulfate (15-20 c.c. of a 3 per cent solution), intravenously; 1 per cent pilocarpine (1 c.c.), subcutaneously; acetycholine; and sympathetic block with novocain.

The use of ergotamine tartrate is contraindicated by the presence of a septic state, cardiovascular disease, or obliterative vascular disease. It

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should be given with great caution to patients with hepatic disease, renal disease, arteriosclerosis, or to those hypersensitive to the drug. (New England J. Med., July 11, '46)

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The Use of Testosterone Propionate in the Treatment of Advanced Carcinoma of the Breast: Adair and Herrmann, working in the Breast Clinic of the Memorial Hospital in New York City, studied the effects of large doses of testosterone propionate in 11 cases of advanced carcinoma of the female breast.

No toxic effects were noted in individuals with normal serum calcium levels, each of whom received several thousand milligrams of testosterone propionate over a period of three months.

Four patients, one with soft-part and three with osseous metastases, manifested remarkable improvement.

The regression of the primary lesion and soft part metastases in one case and an increase in calcification in areas of osseous metastasis in three cases constitute the evidence of improvement.

Disappearance of pain coincided with the favorable bone changes.

In two of the cases that exhibited deposition of calcium in the area involved by the metastases in bone, there was a coincident elevation of the serum alkaline phosphatase.

Four patients did not respond to the therapy and three others are still under treatment without yet showing clinical evidence of improvement. Microscopic study of metastatic nodules from two of the three patients in this latter group revealed hydropic changes.

One patient with an initial hypercalcemia associated with osseous metastases manifested a further rise in serum calcium associated with toxic manifestations in consequence of testosterone therapy. This emphasizes the importance of chemical studies of the blood in patients receiving this treatment.

The authors believe that testosterone propionate in large doses may, in certain instances, exert a favorable influence on advanced carcinoma of the female breast.

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The number of cases studied is too small to gauge the frequency of the occurrence of a favorable reaction. Likewise, the duration of a favorable response and the amount of testosterone propionate necessary to maintain this improved status is as yet unknown. (Ann. Surg., June '46)

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Abdominoperineal Proctosigmoidectomy for Cancer of the Rectum: Restoration of bowel continuity following resection has attracted the attention of surgeons in this country and abroad ever since Reybard more than a century ago successfully removed a sigmoidal cancer and immediately anastomosed the segments. Much progress has been made toward elimination of a colostomy for lesions of the rectum and pelvic colon either by preservation of the sphincter musculature or by re-establishment of continuity.

Dr. Harry Bacon, Professor and Head of the Department of Proctology, Temple University Medical School and Hospital, reviews an experience of over five years in a series of 461 cases of cancer involving the anus, rectum, and pelvic colon, and appraises the results obtained with the technic of proctosigmoidectomy as designed by W. W. Babcock in 1932. The author states that more and more it has been realized in his department that sigmoidal cancers, especially those low in the pelvic colon, can be widely resected with immediate end-to-end anastomosis, and that similar lesions in the rectum can be removed without the establishment of an abdominal colostomy and with preservation of the sphincter musculature. Out of 371 cases in which radical extirpation was performed, 262 (70.6 per cent) were performed without an abdominal colostomy, and of this number, 236 (63 per cent) were operated upon by the technic of proctosigmoidectomy.

It is pointed out that, in general, the matter of spread of the cancer in connective tissue and to lymph nodes in areas below the level of the primary growth is relatively unimportant. Of 49 cases in which the postoperative bowel sections were serially sectioned at 2, 4, and 6 cm. below the growth, extension of the cancer below the 2 cm. level was seen in only one case (which was of grade II). All of these 49 cancers were adenocarcinoma; two were grade I, thirty-eight were grade II, eight were grade III, and one was grade IV.

It is the author's opinion that the sphincter musculature may be preserved provided the lower border of the growth is 6 cm. or more above the anal margin. Based upon a series of 1,995 cases of cancer of the anus, rectum, and sigmoid colon in which the precise location of the tumor was noted in 1401 instances, the author found that only 10.2 per cent of lesions occurred within the distal 5.5 cm. of the bowel, and 19.1 per cent were within the distal 8 cm. Thus, sacrifice of the sphincter musculature is not necessary in roughly 80 per cent

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of cancers involving the distal loop of the large bowel and in these cases preservation of the sphincter musculature does not jeopardize radical extirpation.

Certain details of preoperative preparation, of the abdominal and perineal phases of the operation, and of the postoperative treatment are emphasized.

Following abdominoperineal proctosigmoidectomy, the patients were usually allowed out of bed on the sixth day, and during the last 18 months of the 5-year period covered by this report the majority of the patients were discharged from the hospital on the 11th or 12th postoperative day. About three weeks were usually required for complete healing and closure of the presacral wound resulting from the perineal phase of the operation. Most of the patients in the latter part of the series were able to return to their former (or lighter) occupation in an average of from six to ten weeks. This contrasts with other types of abdominoperineal extirpations as done by the author in which a large perineal wound is made and which requires an average of at least 3 months for healing.

Improvements and refinements in technic, such as establishment of an anterolateral pelvic floor, have prevented descent of the small bowel into the perineal wound; precise maintenance of essential blood supply has avoided retraction and necrosis, and preservation of the sphincter musculature has offered continence in approximately 95 per cent of cases. Between 90 and 95 per cent of these patients become able to carry out their daily occupations without inconvenience.

If one may judge from those patients in whom an abdominal colostomy was transplanted to the perineum, a perineal anus or anal sigmoidostomy is a distinct improvement over even a well-constructed stoma in the abdomen. To date, Babcock and the writer on their respective services have transplanted the abdominal colostomy to the perineum with or without resection in 84 cases with only one death (1.2 per cent mortality). These patients attest that the discharge of offensive gas is much less evident, that the perineal opening is more convenient and easier to care for, and that evacuations are more satisfactory and less frequent than with an abdominal colostomy. (Am. J. Surg., June '46)

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Edema in Ex-Prisoners of War: Edema was observed in 98 of 900 Australians who embarked at Singapore on 22 September 1945.

In 81 of these 98 persons the past history was as follows: They had been taken prisoner in February, 1942, and had either remained on Singapore Island all the time or had been on working parties in Burma and Thailand for various

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periods; 76 had had benign tertian malaria with attacks varying in number from five to fifty, and averaging fourteen; 20 had had malignant tertian malaria; 14 had been infested with some type of intestinal worm; 29 had had scrotal dermatitis; 1 had had pellagra (in 1945); 12 had had glossitis at some time during captivity, and on examination 9 showed smoothness and soreness of the tip and edges of the tongue; 2 had had a form of retrobulbar neuritis; 20 had had the dry form of beriberi and 48 the edematous form. Of the 68 beriberi cases, 67 developed during 1943 and 1944; the exception was a case of wet beriberi which developed in August, 1945. During captivity the diet had consisted mainly of rice, vegetables, and a small quantity of fish.

The edema became evident in these evacuees after they had been on a normal diet for from a few days to several weeks. Some who became affected had not experienced any edema during captivity; one man developed edema for the first time six weeks after the change from rice to a normal diet. The edema fluctuated and was postural. In some cases the edema was very pronounced throughout the day, involving the face and the whole of both legs. There was sometimes a sudden diuresis, with temporary diminution in the edema. Many patients had tender legs and feet after the edema had subsided. The knee jerks were present in all cases. The urine was normal.

Considering the weight before captivity as normal, the average loss in weight of those with edema was 17 lbs. and of those without edema 19 lbs. (50 cases). The blood pressure was taken in 31 cases. In 17 the systolic reading was higher than 140 mm. Hg., and in 7 the diastolic was higher than 90 mm. Hg. The lowest readings found among these 31 men were 130/80 (lowest systolic reading) and 150/75 (lowest diastolic reading), and the highest readings were 160/80 (highest systolic reading) and 150/105 (highest diastolic reading). The usual sequence of events upon subjecting these persons to bed rest was for the blood pressure to fall and the urinary output to rise with a consequent decrease in weight; but after about 3 days the urinary output often decreased, the fluid intake was higher than before (with increase in weight), and the blood pressure increased. There appeared to be a definite correlation between fluid balance and blood pressure.

The appearance of the edema after a return to normal diet is of interest and has been observed by others. If it is conceded that the edema was most likely dietary in origin, the possibility arises that the hypertension had a similar dietary origin.

The author suggests that the increased opportunity afforded by a normal diet and a sedentary life to conserve salt, which previously would have been lost in the sweat incident to enforced labor while on an unfavorable diet, may have been a factor leading to the appearance of a nutritional edema previously rendered latent by salt deficiency. (Lancet, June 8, '46 - Thomas Stapleton)

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Vitamin Retention in Frozen Peas and Frozen Green Beans in Quantity Food Service: Frozen peas and frozen green beans were cooked by three quantity methods. Some of the vegetables were held before serving. Thiamin, riboflavin, and ascorbic acid retentions were determined. The ranges of percentages of vitamin retention during cooking of the peas were: thiamin from 66 to 94; riboflavin from 67 to 98; ascorbic acid from 34 to 69. The corresponding figures for the green beans were: thiamin from 55 to 95; riboflavin from 56 to 93; ascorbic acid from 37 to 55.

All of the thiamin and riboflavin lost from the vegetables was found in the cooking water. During holding after cooking, no change in the thiamin and riboflavin content of the vegetables occurred. Some of the ascorbic acid lost from the vegetables during cooking was found in the cooking water, and some was destroyed. During holding after cooking, the vegetables lost a little more of their ascorbic acid.

The palatability of all of the vegetables decreased progressively upon holding. (J. Am. Dietet. A., June '46 - Briant et al.)

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Ascorbic Acid Content of Freshly Harvested Vegetables: Over a period of three years, the values of ascorbic acid in varieties of 14 kinds of absolutely fresh vegetables were accumulated. It was found that the highest values were in broccoli stems and buds, mustard greens, celtuce leaves, spinach, Swiss chard, and cabbage; the intermediate values in descending order were in carrots, corn, peas, soybeans, snap beans, squash, and rhubarb; and the lowest values were in egg plant, and celtuce stems. (J. Am. Dietet. A., March '45 - Van Duyne et al.)

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Report on Carrots from Studies Carried Out on the Effect of Large-Scale Methods of Preparation on the Vitamin Content of Food: Streightoff et al., working in the Nutrition Laboratory of the Pentagon Post Restaurant, Washington, D. C., carried out a study to determine the vitamin content and percentage of vitamin retention in raw carrots and in carrots cooked by large-scale methods.

The vitamin content of the raw unpeeled carrots varied moderately in the several miscellaneous varieties but only slightly in the ten batches of the Chantenay Coreless variety. Averages of the individual values from the two studies and the range in mg. per 100 Gm. were respectively as follows: carotene, 9.7 and from 7.4 to 12.5; total ascorbic acid, 6.0 and from 5.1 to 6.8; reduced

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ascorbic acid, 5.3 and from 4.1 to 6.3; niacin, .82 and from .57 to 1.46; thiamin, .068 and from .057 to .083; riboflavin, .056 and from .041 to .070; pantothenic acid, .22 (no range); and biotin, .0018 (no range). The concentration of niacin, thiamin, and riboflavin was markedly greater in the portion removed by peeling.

Destruction of ascorbic acid was marked whether carrots were boiled or steamed. The retention of ascorbic acid in steamed carrots was more than double that in boiled carrots. There was additional destruction of ascorbic acid on holding the cooked carrots on the steam table one hour. The proportion of dehydroascorbic acid increased during cooking and holding.

Retentions of the B complex vitamins studied (niacin, thiamin, riboflavin, pantothenic acid, and biotin) were correlated with their solubilities in water. Steamed carrots retained 82 per cent or more of these vitamins; boiled carrots, from 50 to 80 per cent. Most of the vitamins "lost" in boiling were found to be in the cooking water.

Holding of the cooked carrots on the steam table one hour resulted in little or no loss of the B vitamins or carotene. Retention of carotene in cooked carrots was almost complete - from 93 to 96 per cent. The depth of external coloring was a good index of carotene content. Unpeeled fresh carrots and peeled stored carrots on cooking showed similar retention of vitamins.

From the standpoint of flavor, aroma, consistency, and appearance as well as retention of the water-soluble vitamins and solids, steaming is recommended as superior to boiling in the cooking of carrots. It is also recommended that, when possible, raw carrots be prepared for cooking without peeling. (J. Am. Dietet. A. - June '46)

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Effect of Muscular Activity on Bleeding Volume of Normal and Shocked Animals: In order to test the validity of Henderson's postulates regarding the relationship of muscle tone to the venous return in shock, experiments were performed to investigate the effect of drugs which alter muscle tone in normal and shocked mice. The bleeding volume was used as an index of the circulating blood volume and venous return.

The bleeding volume of normal mice was not influenced by nikethamide, a convulsant drug which increases muscle tone, or by curare, which induces muscular paralysis. Neither of these drugs influenced the low bleeding volume of mice in burn shock. General anesthesia itself did not affect the bleeding volume.

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It was concluded that the venous return in normal and in shocked mice was not affected by experimental alterations in muscle tone. (Am. J. Physiol., June '46 - Bergman et al.)

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Studies in Animals on the Value of Alkalinizing Agents in Preventing the Transition from Impending to Irreversible Shock: In studies carried out in dogs by Wiggers and Ingraham in the Department of Physiology of the University of Illinois College of Medicine, it was found that the continuous intravenous infusion of sodium lactate throughout a 90-minute period of hemorrhagic-hypotension (40 mm. Hg.) does not effectively prevent the development of acidosis and lower the mortality rate experienced in a series of untreated control dogs. It is postulated that the severe anoxia created by the experimental conditions interfered with metabolic functions to the extent that the maximal alkalinizing effects of the lactate administered were never realized.

In many animals, however, a similar continuous infusion of sodium bicarbonate proved an effective anti-acidotic treatment and prevented the development of irreversible shock. In several other dogs, in which the quantity of bicarbonate administered was inadequate to prevent some degree of acidosis from developing, irreversible shock did set in. It seems obvious that in many instances the transition from the impending to the irreversible shock state is significantly accelerated by an existing acidosis. It is suggested, a priori, that sodium bicarbonate infusions should be more frequently employed in severe hemorrhagic conditions in which acidosis is already present or is likely to develop before adequate blood replacement can be instituted. (Am. J. Physiol., June '46)

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Serological Study in Tsutsugamushi Disease (Scrub Typhus): Bengtson, at the National Institute of Health of the U. S. Public Health Service, carried out a serological study on specimens of blood serum furnished from 37 cases of tsutsugamushi fever which occurred in Burma and the Philippine Islands during 1944 and 1945. Several specimens taken at different times during the disease and during convalescence were furnished in many of the cases. The author used Proteus OXK (Kingsbury) antigen in the Weil-Felix agglutination test, and in the complement-fixation tests she used antigens made from rickettsia of the Karp, Gilliam, and Seerangayee strains grown in egg-yolk sac.

Previous studies of serums from accidental laboratory infections in human beings and of serums from guinea pigs inoculated with known strains of the rickettsia of tsutsugamushi fever had shown that higher complement-fixation

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titers were obtained when antiserums were tested against the infecting strain than when they were tested against other strains.

The results of the tests in this study do not indicate any clear differentiation of serological types. Although a certain number showed a decidedly higher complement-fixing titer against either the Karp, Gilliam, or Seerangayee strain, the same or approximately the same titer against all three of the strains used in the preparation of the antigens was shown in a considerable number of the cases.

Certain cases were predominantly of the Gilliam type, others of the Karp or Seerangayee type, and the serums of a number of cases responded equally well to all three types. Cross fixation occurred in practically all cases.

The Karp and Gilliam strains appear sufficiently distinctive, however, to warrant the use of those two in the testing of serums from cases of suspected tsutsugamushi disease. The titers shown in the Weil-Felix test using the Kingsbury strain of Proteus (OXK) antigen were much lower than the titers in the complement-fixation test against the rickettsial antigens and persisted for a shorter time. In several of the cases, the titers in the Weil-Felix test, as shown by the antigen used by Bengtson, were negative or too low to be of any diagnostic aid at a time in the course of the disease when positive laboratory findings would be most helpful, whereas the complement-fixation test done at the same time, in one or two of the cases, was positive. (Pub. Health Rep., June 14, '46)

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Development of Gastric Ulcer in Patient Receiving Histamine Daily: Iams and Horton of the Mayo Clinic report the case of a man in whom a stomach ulcer appeared during treatment for multiple sclerosis which included daily intravenous injections of histamine. The authors conjecture that possibly because this patient had neglected to eat immediately before each injection, the gastric ulcer developed. The histamine therapy was promptly discontinued and the ulcer healed in 12 days. (Gastroenterology, May '46)

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(Not Restricted)

Re Lineal Position of Officers Transferred to Regular Navy: A severe degree of apprehension and dissatisfaction has developed on the part of a number of Reserve medical officers regarding initial permanent appointments in the regular Navy tendered by the Bureau of Naval Personnel pursuant to applications filed by transferees in accordance with the provisions of Bureau of Naval Personnel Circular Letter #288-45 (revised). This appears to be clearly a case of misunderstanding by such transferees of the salient features of rank redistribution that will take place along with the termination of all temporary appointments and in this connection, attention of all candidates is invited to the provisions of paragraph 10(b) of Bureau of Naval Personnel Circular Letter #123-46 and the provisions of Bureau of Naval Personnel Circular Letter #169-46 which assures all transferees of absolute equity with regular officers in the final establishment of their lineal position. The latter two references are quoted below for the information of all transferees not having access to the Navy Department Semimonthly Bulletin and related publications:

(Paragraph 10(b) - BuPers Circular Letter #123-46):

> The permanent appointments offered at this time to officers transferring to the Regular Navy are initial permanent appointments which will remain in effect only until the redistribution of officers takes place and temporary appointments are terminated. These initial permanent appointments correspond to those now held by officers in the Regular Navy of the same temporary rank and date of rank. When the redistribution of Regular officers takes place and temporary appointments are terminated, all officers will receive a permanent appointment in a rank which is expected to be either the same as their present temporary rank or one rank lower than their present temporary rank.

(BuPers Circular Letter #169-46)

To: All Ships and Stations. 17 July 1946

Subj: Lineal Position of Transferred Officers - Basis for Determination of.

1. Numerous inquiries have been received in this Bureau which indicate that many officers are misconstruing the significance of the permanent dates of rank assigned to those officers transferred to the regular Service whose names are listed in Bureau of Naval Personnel Circular Letters 123-46, 134-46, and 148-46. The dates of rank assigned in these circular letters are applicable only when used in conjunction with the transfer law and regulations and do not when used alone, indicate final seniority.

(Not Restricted)

2. Officers are being transferred to the regular Service with the same seniority which they hold at the time of transfer and are being assigned lineal positions in the regular Service according to their present restricted temporary rank and date of rank. It is emphasized that the permanent dates of rank that have been assigned transferred officers do not in themselves indicate relative lineal positions of any officers with respect to other officers.

3. Since the assignment of permanent dates of rank has lead to some uncertainty on the part of individuals relative to their lineal position, the practice is being discontinued and the dates previously published shall be disregarded. Initial permanent appointments issued to transferring officers henceforth will not include a date of rank.

4. These initial permanent appointments will be replaced at a later date by new permanent appointments with dates of rank which will establish each officer's lineal position in the regular Service. --Louis Denfeld.

(Assistant Chief of Bureau for Professional and Personnel Operations, BuMed)

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(Not Restricted)

Physical Qualifications for Transfer to Regular Navy and Marine Corps:

The attention of medical and dental examiners is called to Alnav 271 of 19 September 1945 which is recopied here as follows:

Alnavs 202, 206, 207, 208, all 1945. Reserve officers and temporary officers in Navy and Marine Corps who desire to transfer to Regular Navy and Marine Corps have been requested to submit their applications to Chief of Naval Personnel and Commandant, U. S. Marine Corps.

To comply with instructions that have been issued, these officers must submit with their applications for transfer a report of a physical examination on NavMed-Y, or NavMed-AV-1 for flying officers, in duplicate.

The Manual of the Medical Department does not contain a description in chapter 11 of physical standards for transfer of Reserve and temporary officers to the Regular service. It does, however, give the physical standards for promotion of officers. Since the officers requesting transfer are required to meet the same physical requirements as those officers now in the Regular service who will be their contemporaries, the standards for promotion and not for original commission must be considered where their age and rank warrant.

Standards for promotion allow the medical officer a wide margin in determining his recommendation as to whether or not Reserve and temporary officers are physically qualified for transfer to the Regular service. In view of this, the medical officers must carefully consider each applicant's (a) medical history prior to his entry into the service, (b) medical history during active duty, and (c) present physical condition and ability to adjust to the service.

The examiners should carefully evaluate all defects in a given case before making a recommendation. Regular-service officers are expected to serve for a given number of years. Many Reserve and temporary officers have been able to perform their duties in a satisfactory manner during this war with physical defects which will disqualify them for the Regular service because their defects are either progressive or recurrent in nature. Examples of diseases which fall in this classification are: Peptic ulcer, arterial hypertension, asthma, psychoneurosis, rheumatic fever, internal derangement of knee joint, migraine, fungus infection of skin, etc.

Since the physical standards for transfer depend upon the applicant's age, rank, ability to perform duty at sea or in the field, and probable ability to perform active duty for either 20 or 25 years, each request for transfer will require a certain amount of study by the medical examiners. For example, an officer of the line with the rank of lieutenant may be recommended for transfer with 8/20 vision provided his visual acuity is corrected to 20/20 and provided he is free from organic disease and has been able to perform deck duty at sea without difficulty. A commander may be recommended for transfer in either the line or staff corps with absence acquired teeth provided he has satisfactory replacements and can perform his duties at sea.

(Not Restricted)

Many of the causes for rejection for commission or enlistment in chapter 11 of the Manual of the Medical Department remain valid and would ordinarily disqualify for transfer. A number of officers will request transfer and present ample evidence that a given minor defect is not a handicap in their case. However, it is suggested that medical officers review the picture as a whole and consider the question of motivation in each case. The local board or commanding officer may request a waiver for minor physical defects in cases of outstanding officers who are otherwise eligible. Requests for waivers should be entered on the NavMed-Y or NavMed-AV-1 under the appropriate heading of recommendations.

A recent chest X-ray examination (within 6 months) and a current blood Kahn is required for all officers entering the Regular service and it is recommended that these reports be incorporated on the NavMed-Y or NavMed-AV-1 or forwarded at a later date when it is not practicable to obtain them at the time of the examination. These examinations will not be repeated during the final physical examination just prior to delivery of the commission to Regular Navy unless it is deemed necessary by the medical examiner because of a recent illness, loss of weight, etc.

There must in every case be appended to the report a certificate sworn to by the candidate as follows: "I certify that I have informed the medical examiners of all bodily or mental ailments which I have suffered, and that, to the best of my knowledge and belief, I am at present free from any bodily or mental ailments (except_____). Name:_____ Rank:_____
Sworn to and subscribed before me this_____ day of_____19___.
Name:_____Rank:_____"

Upon the completion of the NavMed-Y or NavMed-AV-1, the following statement is required: "We certify that the candidate is (is not) physically qualified for transfer to the U.S. Navy or Marine Corps as _____."
Rank Corps

The report of medical examination is to be forwarded with the application to the Chief of Naval Personnel or Commandant, Marine Corps, as applicable. The form of report described in chapter 12 of Naval Courts and Boards is neither required nor desired. Such preliminary examination does not take the place of a later demonstration of physical fitness prior to acceptance of an appointment if selected for transfer.—SecNav. A. L. Gates

(PQ and MR Div., BuMed)

Note: Also see BuPers Circular Letter 123-46, as mentioned in the following item.

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(Not Restricted)

Appointment in the Line and Staff Corps of Certain Temporary Commissioned and Naval Reserve Officers: The attention of members of Boards of Medical Examiners is called to BuPers Circular Letter No. 123-46 on page 149 of the Navy Department Semimonthly Bulletin of 31 May 1946.

The parts of the letter having to do particularly with the requirements concerning the physical condition of appointees are paragraphs (2) and (7) which are reprinted here.

2. Of those officers listed, the following are excepted from this appointment authority:

(a) Any officer under disciplinary action or awaiting such action.
(b) Any officer on sick leave or under treatment in a hospital (medical officers in command of hospitals are enjoined to advise BuPers in such instances; personnel concerned will be considered later for appointment when and if the officer concerned is found to be physically qualified).
(c) Any officer who, upon examination as directed in paragraph 7 hereof, fails to qualify physically for permanent appointment in the U. S. Navy.

7. The appointment of each individual pursuant to this authority shall be subject to qualification on physical examination. Such physical examination shall be conducted by a board consisting of one or more medical officers and one dental officer. The report of each such board shall be signed by all its members who shall be governed by the instructions contained in this paragraph.

(a) No person shall be appointed to permanent commissioned rank, above commissioned warrant, unless he is physically qualified to perform all the duties at sea of the rank in which serving at the time of this examination.

(b) No person shall be appointed to permanent commissioned warrant or warrant grade unless he is physically qualified to perform all the duties of such commissioned warrant or warrant grade.

(c) A careful review of the current health record shall be made in each case followed by a complete physical examination. An X-ray of the chest and a current blood Kahn are required if records of such examinations were not forwarded with the application for transfer. The report of physical examination shall be forwarded to the Bureau of Medicine and Surgery on NavMed-Y, or NavMed-AV-1 for flying officers, and shall include the following statement: "We hereby certify that the candidate is (is not) physically qualified for appointment in the United States Navy as.....
....."

1. There must in each case be appended a certificate sworn to by the appointee as follows: "I certify that I have informed the board of medical officers of all bodily or mental ailments which I have suffered and

(Not Restricted)

to the best of my knowledge and belief I am at present free from any bodily or mental ailment (except as follows.....)."

2. Individuals who have developed physical defects since submitting their applications for transfer which are sufficient to disqualify for appointment or who have been admitted or treated for illnesses which are progressive or recurrent in nature shall not be found physically qualified for permanent commission. Examples of diseases which fall in this classification are: Peptic ulcer, arterial hypertension, asthma, psychoneurosis, rheumatic fever, internal derangement of knee joint, migraine, fungus infection of skin, etc.

(d) If upon physical examination the candidate concerned is found to be physically qualified in all respects the appointment may be delivered. If definitely not qualified the appointment will not be effected.

(e) In questionable cases where the health record contains entries which require a review of the applicant's medical file in the Department or for any other reason a definite finding may not be made at the time of examination, the report of the board shall be forwarded to the Bureau of Naval Personnel via the Bureau of Medicine and Surgery. In such cases the appointment shall be withheld until further advised in the premises.

(PQ and MR Div., BuMed)

Note: Also see item preceding on "Physical Qualifications for Transfer to Regular Navy and Marine Corps."

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(Not Restricted)

Policy Regarding Requisitioning of Certain New Items of Dental Material:

Several new items of equipment have been added to the BuMed Section of the Catalog of Navy Material. Inasmuch as some of these items are not required for each dental operating room and since no symbols limiting requisitioning are listed in the catalog, the following general policies are offered as guides in requisitioning these items.

5-005-010 Amalgamator, Mechanical

5-005-050 to 5-005-550 Accessory replacement parts for the Amalgamator

This item is available for each dental officer engaged in operative dentistry. It is not considered necessary for replacement parts to be ordered with each amalgamator, since the amalgamator is complete with accessories. dental departments with 5 or more dental officers should stock one set of accessories.

(Not Restricted)

5-013-510 Aspirator, Mobile

This item will not ordinarily be required in dental operating rooms having the present Ritter senior dental units since these units have aspirators. Large dental activities may have use for a mobile aspirator in the dental surgery. When requisitioning this item justify the need on the reverse of the Form NavMed-4.

5-174-015 Compressor, Air, 8 gal. tank
5-175-008 Compressor, Air, 40 gal. tank

5-175-125
to Compressor parts
5-176-000

BuShips letter S37-1(640-250)EN28/A2-11 of 10 May 1946 to All Ships and Stations authorizes that compressed air be made available in the future from the ship's service air main. Order compressors when needed. Parts for compressors will not be maintained as shelf stock except at very large dental activities.

5-196-600 to 5-196-900 Curettes
5-240-050 to 5-252-000 Elevators
5-313-150 to 5-326-420 Forceps, etc.
5-372-350 to 5-372-550 Periodontal knives
5-409-050 to 5-409-550 Periodontal pocket markers

Surgical equipment should be requisitioned on the basis of the number of dental operating rooms set up as dental surgeries. Generally, it is expected that one set of surgical equipment should suffice for a four-room dental operating clinic.

5-223-050)
5-453-650)
5-453-750) Diamond Drills and Disk
5-453-800)

These items are mainly required in prosthesis and should be ordered on the basis of the number of prosthodontists. Other diamond drills will be needed for both operative and prosthetic dentistry.

(Not Restricted)

5-253-008 Engine, Dental, Mobile
5-388-005 Lamp, dental operating, wall bracket type

Only certain large dental surgeries should require these items, particularly where an additional surgical chair is installed. Justify your need when requisitioning.

5-326-605 Fracture set, Mandible

Not issued routinely. Should be requisitioned only by dental activities when the case load so justifies.

5-116-450 Casting machine, small, with accessories
5-327-325 Furnace, Dental Lab., Small

These items are not intended for general issue. They may be required for expanding large laboratories as accessory equipment, or for small laboratories with limited space. Justify your need when requisitioning.

5-327-650 Furnace, Porcelain
5-565-150 Soldering machine, dental

To be issued only to large laboratories and where there is particular need for this equipment.

5-390-050
to Chucks for dental lathe
5-390-450

Lathes come originally with a set of chucks.

(Not Restricted)

5-396-150	Mallet, gold foil, automatic
5-396-450 to 5-398-050	Accessories for Mallet
5-401-000	Mallet, Plugging

It is not expected that every dental operating room (in clinics with more than one dental officer) will require the gold mallet and accessories. One set should be adequate for three officers in clinics with three or more dental officers. The accessories are not included with 5-396-150 and must be ordered separately.

5-399-150	Mallet, oral surgery, Dudley
5-399-250 to 5-399-650	Mallet accessories

The surgical mallet will be requisitioned on the basis of the number of operating rooms set up as dental surgeries (about one to four in a large dental clinic). The accessory points are a part of 3-399-150 and should not be ordered as shelf stock.

(Dental Div., BuMed)

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(Not Restricted)

Navy Releases More Than 500 Training Films for Non-Service Uses: More than 500 training films and film strips are being released by the Navy Department for general use by educational institutions, civic groups, health and medical groups, and manufacturers.

Although security measures still withhold from general use a major portion of films produced during the war, additional releases are expected to be made in the future.

Of special interest are films dealing with engineering, aviation, machine-shop work, office practices, shipbuilding, supervision, nursing, optical craftmanship, welding, aerial navigation and flying, aircraft maintenance, safety and

(Not Restricted)

first aid, electricity and radio, aerology, hydraulics, mechanical refrigeration, fireroom operations, medical and dental technics, diesel engines, and plastic surgery.

All medical and related films, with the exception of those dealing with first aid, will be restricted in use to medical schools, medical groups, and associated instructional agencies.

These films will be available in the early fall through the United States Office of Education, Washington, D. C., to which all inquiries should be addressed.

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(Not Restricted)

Specimens of Pathology Desired by the U. S. Naval Dental School: It is requested that gross oral pathological material, either antemortem or postmortem, fixed in 10 per cent neutral formalin, be forwarded to the Commanding Officer, Naval Dental School, National Naval Medical Center, Bethesda, Maryland, together with the following clinical data.

Name_____ Age_____ Rate_____
Location and Duration of Lesion_____
Kind of Tissue and how Obtained_____
Clinical Impression_____
Remarks_____

Signature_____ (DC), USN
(rank)

This material is desired for teaching purposes and as an aid in maintaining the Archives of Oral Pathology of the Dental School in a current status. Pathological diagnosis will be given by the school whenever this service is desired. (Dental Div., BuMed)

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(Not Restricted)

Reduction in Requirement for Active Duty Service of Dental Officers of Naval Reserve: In accordance with Alnav 379-46, effective September 1, 1946, the active duty service requirement for those dental officers of the Naval Reserve affected by Alnav 281-46 will be 30 months instead of 36.

This change in the length of active duty required for Reserve dental officers will affect approximately 1,500 officers.

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(Not Restricted)

Re Listing in Navy Register of Special Courses and Qualifications of Dental Officers: It is noted that the "Special Courses and Qualifications" column of the Navy Register does not contain designations for special courses and qualifications with which certain dental officers are otherwise credited. Attention is invited to the fact that paragraph 5 of the "Notes" appearing in the Navy Register directs that officers concerned report errors or omissions to the Bureau of Naval Personnel. It is requested that a carbon copy of any letters of notification in this regard be forwarded to BuMed. (Dental Div., BuMed)

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(Not Restricted)

Legislation will be Requested to Establish Navy Nurse Corps as Staff Corps of Regular Navy: Legislation to establish the Navy Nurse Corps as a staff corps of the regular Navy with permanent commissioned rank for its members is being drafted for action by Congress.

Under an act of Congress of February 1944, Navy nurses were given temporary commissioned rank status for the duration of the war and six months thereafter. The congressional act which officially established the Navy Nurse Corps in 1908 gave its members military status but did not officially designate them as officers or enlisted.

The legislation to be requested would give members of the Nurse Corps permanent commissioned rank, from ensign to captain inclusive, with equal pay, allowances and benefits of other officers of the regular Navy.

Pending enactment of the legislation, Navy Reserve nurses are urged to apply for transfer to the regular Navy, and qualified registered civilian nurses are being recruited for temporary commissions in the Nurse Corps.

Navy Reserve nurses who served in World War II are eligible to transfer to the regular Navy provided they have not reached their thirty-eighth birthday. If in an inactive status, they may submit applications for transfer within six months after the expiration of their terminal leave.

Registered civilian nurses between the ages of 22 and 30 who desire a Navy career are urged to contact the Naval Officer Procurement office in their locality for information concerning appointment to the Nurse Corps. Preference will be given those civilian nurses with at least one year of graduate nursing experience.

Postwar plans based upon the proposed legislation call for a regular Navy Nurse Corps of approximately 2,700 members. Under the plans, approximately

(Not Restricted)

1,000 officer billets will be filled by appointees from the Navy Reserve or from among civilian nurses.

The prewar strength of the Navy Nurse Corps was approximately 500, as compared with a wartime peak of 11,000 reached just prior to the end of the war with Japan. Of the 11,000 wartime nurses, approximately 9,000 were Reservists. (Personnel Div., BuMed)

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(Not Restricted)

Changes to be Made in Copies of Manual of the Medical Department: A change in the Manual of the Medical Department has been directed, as specified in Circular Letter, "Dependents of Coast Guard Personnel, Hospitalization and Treatment of," on page 28 of this issue.

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(Not Restricted)

Public Health Foreign Reports:

Disease	Location	Date	Number of Cases
Cholera	India, Bengal	Rep. Dtd. June 7, '46	1,300 fatal (1 wk.)
	Bihar		2,400 fatal (1 wk.)
	United Provinces		1,700 fatal (1 wk.)
	Indochina (French), Cochinchina	May 11-20, '46	109
	Thailand (Siam)	May 18-25, '46	238
Plague	Egypt, Alexandria	May 25-June 1, '46	4
		June 11-18, '46	8 (3 fatal)
	Suez	May 25-June 1, '46	5
		June 11-18, '46	4
	Great Britain, Malta	June 1-8, '46	1
	Indochina (French), Cochinchina	May 11-20, '46	1
	Peru, Lima Dept.	April '46	1
Smallpox	Mexico	May '46	78
	Morocco (French)	May 21-31, '46	61
	Nigeria	Mar. 9-Mar. 30, '46	1,255 (186 fatal)
	Thailand (Siam)	May 18-25, '46	771

(Not Restricted)

Public Health Foreign Reports (Cont.)

Disease	Location	Date	Number of Cases
Typhus Fever	Belgian Congo	June 1-8, '46	103
	Bulgaria	May 11-18, '46	50
	Ecuador	May '46	65 (3 fatal)
	Mexico	May '46	124
	Morocco (French)	May 21-June 10, '46	437
	Peru	April '46	102
	Straits Settlement, Malacca	June 8-15, '46	5
Yellow Fever	Colombia, Magdalena Dept., Municipality of Plato	Mar. 31, '46	1 fatal
	Santander Dept., Municipality of La Paz, Cachipay	Jan. 1-Feb. 28, '46	1 fatal
	Nigeria, Oyo Province, Ogbomosho	May 17, '46	25 (24 suspected 1 fatal)
	Sierra Leone, Pujehan	June 20, '46	1 suspected fatal

(Pub. Health Reps., July 5, 12, and 19, '46)

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(Not Restricted)

Need Existing for Repeat Action Directed in Alnav 78-46: Because of the number of inquiries and requests directed to BuMed recently regarding Health Records, it is requested that all concerned repeat action called for in Alnav 78 of 13 Feb 1946 which reads as follows:

> Check all Health Records now on board against muster roll and forward records of individuals not attached and whose present stations cannot be ascertained to the Bureau of Medicine and Surgery immediately.
>
> (PQ and MR Div., BuMed)

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(Not Restricted)

To: All Naval Stations
All Marine Corps Activities.

BuMed-WH-GC
ET14/A3-1
17 June 1946

Subj: Dependents of Coast Guard Personnel, Hospitalization and Treatment of.

Ref: (a) Executive Order 9666, of 29 Dec. 1945 (G.O. 229).
(b) Par. 415.3, Manual of the Medical Department 1945.

1. Under the terms of Executive Order No. 9666, the President directed that the Coast Guard shall operate under the Treasury Department on and after 1 January 1946. Said Executive order further provides that such Coast Guard vessels, facilities, and personnel as the Secretary of the Treasury and the Secretary of the Navy may mutually agree upon shall continue to operate as part of the Navy for such periods of time beyond 1 January 1946 as the respective Secretaries may provide.

2. Under provision of Executive Order No. 9666, the Medical Department of the Navy is authorized to furnish hospitalization and medical care of dependents of Coast Guard personnel only under the following circumstances:

(a) Dependents of Coast Guard personnel who continue to serve under the jurisdiction of the Navy.
(b) Dependents of Coast Guard personnel who were hospitalized or receiving medical care prior to 1 January 1946 and the immediate discontinuation of treatment or hospitalization would, in the opinion of medical authority, be detrimental to their health. Treatment of such dependents may continue for such periods of time as may be necessary to protect their health.

3. In accordance with the above policy, reference (b) shall be modified as follows:

Delete par. 415.3 and substitute:

"Par. 415.3. Dependents of Coast Guard personnel specified in paragraph 415.2 shall be given medical care and treatment at naval medical facilities only if the individual is a dependent of a member of the Coast Guard who is on duty at an activity which operates as a part of the Navy."

--SecNav. James Forrestal.

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(Not Restricted)
Op21D-jc
Serial 3369P24
27 June 1946

To: All Ships and Stations, Bureaus, Boards, and Offices, Navy Department, Headquarters, U. S. Marine Corps.

Subj: Reorganization to Provide More Efficient Dental Care for the Personnel of the United States Navy.

1. Public Law 284, 79th Congress, 1st Session, approved 28 December 1945, requires the reorganization of the Bureau of Medicine and Surgery so as to provide for greater integrity of the dental service. It also requires that the Secretary of the Navy shall provide by regulations for establishing on ships and on shore stations dental services to be under the senior dental officer, who shall be responsible to the commanding officer of such ship or shore station for all professional, technical, and administrative matters in connection therewith, the foregoing being subject to the qualification that it shall not be construed to impose any administrative requirements which would interfere with the proper functioning of battle organizations. Accordingly, the following reorganization shall become effective as of 28 June 1946.

2. A Dental Division is hereby established in the Bureau of Medicine and Surgery which shall study, plan, and direct all matters coming within the cognizance of such division, and all matters relating to dentistry shall be referred to the Dental Division. The Dental Division shall (1) establish professional standards and policies for dental practice; (2) conduct inspections and surveys for maintenance of such standards; (3) initiate and recommend action pertaining to complements, advancement, training, assignment, and transfer of dental personnel; and (4) serve as the advisory agency for the Bureau of Medicine and Surgery on all matters relating directly to dentistry.

3. Where dental services are or shall be established on ships and on shore stations, such services shall be under the senior dental officer, who shall be responsible directly to the commanding officer of such ship or shore station for all professional, technical, and administrative matters in connection therewith. Administrative action taken pursuant to this paragraph shall be such as not to interfere with the proper functioning of battle organizations.

4. All dental reports and other communications pertaining to dentistry or dental personnel shall be forwarded to the Bureau of Medicine and Surgery or to other higher authority via the commanding officer.

5. The care and treatment of all dental conditions shall be directly under the control of the senior dental officer, who shall be responsible to the commanding

(Not Restricted)

officer. Medical officers shall refer dental conditions to dental officers when such are available. For medical assistance in unusual and emergency situations and for organization and training for battle, dental personnel and equipment shall be under the command and control of the medical officer when so assigned by the commanding officer or as provided in battle and emergency bills. The term "dental personnel" as used herein shall include all officers of the Dental Corps and such other officers and enlisted personnel as may be assigned to the dental department by the commanding officer or higher authority.

6. Dental supplies, equipment, and services shall be procured under established procedure until such time as further directives and instructions are issued pursuant to paragraph 7 hereof. Senior medical officers of all ships and stations shall transfer to senior dental officers on NavSandA 127 dental equipment, dental supplies, and such medical supplies as may be necessary. Supplies and equipment, other than that under the cognizance of the Bureau of Medicine and Surgery, required for the maintenance and operation of the dental department shall be issued to the senior dental officer by the appropriate custody or issue voucher. Commanding officers are directed to provide proper and adequate storage and safekeeping facilities for dental supplies, including drugs, narcotics, and precious metals.

7. Changes in Navy Regulations, Navy Department general orders, and bureau manuals, and detailed directives and instructions required to implement Public Law 284, 79th Congress, will be promulgated at the earliest possible time. Pending such promulgation, all members of the naval service affected by this directive shall employ their best efforts to provide that the changes required shall be so effected as to maintain efficiency and economy. It is considered that the changes necessitated by Public Law 284, 79th Congress, can be accomplished through the conscientious efforts of all concerned.

--SecNav. John L. Sullivan.

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To: All Ships and Stations. 28 June 1946 (Not Restricted)

Subj: General Order No. 238 - Repression of Prostitution.

1. General Order No. 238, quoted below, is promulgated in advance of printed copy.

- - OpNav. R. L. Conolly.

GENERAL ORDER
No. 238

(Not Restricted)
Navy Department,
Washington, D. C., 23 June 1946

REPRESSION OF PROSTITUTION

1. The control of venereal diseases is part of the established policy of the Navy Department in its general program for the welfare of the personnel. It has been repeatedly demonstrated that the toleration of organized prostitution is a completely ineffective method of controlling venereal diseases, and that, on the contrary, prostitution contributes to a materially higher incidence of these diseases. In addition, the toleration of prostitution is medically unsound, socially objectionable, potentially destructive of morale, and is distinctly contrary to the desires of the citizens of the United States.

2. In accordance with the policy of repression of prostitution, it is the responsibility of the commanding officers within the continental United States and of naval forces afloat and overseas to secure compliance with the following regulations:

(a) All identified houses of prostitution will be declared out of bounds. Action taken in this connection will be coordinated with proper Army authorities as provided for in the Joint Agreement of 29 August 1944 on Joint Army-Navy Disciplinary Control Boards.

(b) Disciplinary measures will be taken against all military personnel entering a house of prostitution either known by them to be such or having been declared out of bounds by proper authority; provided, however, that such personnel are not acting in an official capacity and on orders from competent authority.

(c) Full cooperation will be given civilian and other Government agencies engaged in the repression of prostitution and the elimination of sources of venereal infection.

(d) All practices which can in any way be interpreted as fostering, regulating, or condoning prostitution will be prohibited, and violations handled through appropriate disciplinary action.

(e) Commanding officers will continue to utilize every other means at their disposal to reduce the incidence of venereal disease in their respective commands, including the use of educational and prophylactic measures.

FORRESTAL,
Secretary of the Navy.

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To: All Naval Activities Ashore. 19 June 1946 (Not Restricted)

Subj: Administration Naval Reserve Medical Officers Assigned to Hospitals of the Veterans' Administration.

Ref: (a) Alnav 281-46; N. D. Bul. of 31 May 1946, 46-1122.

1. A number of Naval Reserve medical officers on active duty under the provisions of reference (a) will be assigned duty with hospitals of the Veterans' Administration.

2. Initial assignment, reassignment, promotion, and separation functions will be exercised by the Bureau of Naval Personnel, Navy Department, on the recommendation of the Veterans' Administration.

3. (a) Medical officers assigned to duty with hospitals of the Veterans' Administration will report to the manager of the hospital in person, and by letter to the commandant of the naval district or river command in which the hospital is located.
   (b) Medical officers are under the command of the commandant of the naval district or river command for purpose of pay, discipline, leave, court-martial jurisdiction, uniform regulations, fitness reports, and other related matters.
   (c) The professional duties of these medical officers will be as directed by the Veterans' Administration.

4. When quarters are assigned, including Veterans' Administration quarters, officers will have their rental allowance checked in accordance with existing Navy Department directives. When an officer considers that the quarters assigned are inadequate the case will be referred to the commandant for decision.

--BuPers. T. L. Sprague.

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To: All Ships and Stations. 24 June 1946 (Not Restricted)

Subj: Surface Vessels in Commission, Modification of Sick-Bay Berthing.

Ref: (a) BuShips ltr. S33-6-(18)(631), EN28/A2 11, of 12 Apr. 1946; N. D. Bul. of 15 Apr. 1946, 46-788.

1. Supplementing instructions of reference (a), ships to which full complements are not attached are authorized to dismantle and stow on board sick-bay

(Not Restricted)

berths as indicated below, provided such accommodations can at all times be restored within 10 days using only ships' force and available shipboard facilities:

(a) All surface vessels except tenders and hospital ships - berths in excess of 2 per cent of personnel allowance.
(b) Tenders - berths in excess of 4 per cent of personnel allowance.
(c) Hospital ships - no reduction.

--BuShips. S. S. Kennedy.

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To: All Ships and Stations 19 June 1946 (Not Restricted)

Subj: U. S. Naval Medical Center, Guam, Marianas Islands - Command Relationship of.

Ref: (a) SecNav ltr. Op24B-pd, serial 395P24, of 15 Mar. 1946; N.D. Bul. of 31 Mar. 1946, 46-597.

1. Reference (a) is hereby modified as follows:

(a) The U. S. Naval Medical Center, Guam, Marianas Islands, is placed under the military command and coordination control of the Naval Governor of Guam.
(b) The Guam Memorial Hospital and the School of Medical Practitioners are placed under the management control of the Naval Governor of Guam.

2. Bureaus and offices concerned take necessary action.

--SecNav. James Forrestal.

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To: All Ships and Stations 20 June 1946 (Not Restricted)

Subj: U. S. Naval Hospital, Guantanamo Bay, Cuba - Establishment of.

1. The following activity was established, effective 1 June 1946, under a Medical Officer in Command, and designated:

U. S. Naval Hospital, Naval Operating Base, Guantanamo Bay, Cuba,
Mail Address: Navy #115 (one-one-five), FPO, N.Y., N. Y. 3435-352

(Not Restricted)

This is a subordinate activity of the Naval Operating Base, Guantanamo Bay, and an activity of the Tenth Naval District, under the management and technical control of the Bureau of Medicine and Surgery.

2. Bureaus and offices concerned take necessary action.

--SecNav. James Forrestal.

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To: All Ships and Stations 25 June 1946 (Not Restricted)

Subj: U. S. Naval Medical Supply Depot, Balboa, C.Z. - Redesignation of.

1. The U. S. Naval Medical Supply Depot, Balboa, Canal Zone, is redesignated, effective 1 July 1946, under an officer in charge, as follows:

U.S. Naval Medical Supply Storehouse, Balboa, Canal Zone.
Mail Address: Navy #121 (one-two-one), FPO, N.Y., N. Y. 4194-008

This is an activity of the Fifteenth Naval District under the management and technical control of the Bureau of Medicine and Surgery.

2. Bureaus and offices concerned take necessary action.

-- SecNav. John L. Sullivan.

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To: All Ships and Stations 25 June 1946 (Not Restricted)

Subj: U. S. Naval Medical Research Laboratory, Submarine Base, New London, Conn. - Establishment of.

1. The following activity is hereby established under an officer in charge and designated:

U. S. Naval Medical Research Laboratory, Submarine Base,
New London, Connecticut. 3860-578

This is a subordinate activity of the U. S. Naval Submarine Base, New London, and an activity of the Third Naval District, under the management and technical control of the Bureau of Medicine and Surgery.

2. Bureaus and offices concerned take necessary action.

-- SecNav. John L. Sullivan.

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Circular Letter 46-107 15 July 1946 (Not Restricted)

To: All Ships and Stations.

Subj: Physical Medicine - Specialization Course in.

Refs: (a) Catalog of Hospital Corps Schools and Courses, Revised 1944 (NAVMED-367).
(b) Addendum to Catalog of Hospital Corps Schools and Courses, Revised 1944 (NAVMED-637).
(c) BuMed CirLtr 45-17, 20 Jan 1945 (Bull. BuMed CirLtrs. July 1939-July 1945 or N.D. Bull. Jan-June 1945, Item 45-85, p. 319).

Encl: 1. (HW) Curriculum, compendium and requirements for course in Physical Medicine. *

1. A specialization course for enlisted personnel of the Hospital Corps in Physical Medicine is hereby established and shall be made a part of ref (a). This course will replace the specialization course in Occupational Therapy and Physical Therapy.

2. In the Catalog of the Hospital Corps Schools and Courses, Revised 1944, delete Pages 27, 32, 70 and 74. On Page 5 delete the parts pertaining to Physical Therapy and Occupational Therapy. On Page 39 delete part pertaining to AP 7.

3. Delete those parts in ref (b) and (c) pertaining to Certificate in Occupational Therapy and Certificate in Physical Therapy.

4. Enclosure #1 sets forth the curriculum, compendium and minimum and desirable requirements for nomination to this course.

5. The length of subject course is six (6) months. During the course men will be selected to specialize in either Physical Therapy or Occupational Therapy. Upon successful completion they will be designated as a Physical Therapy Technician if they receive the subject of Physical Therapy Specialization or an Occupational Therapy Technician if they receive the subject of Occupational Therapy Specialization. The instruction center for subject course shall be the U. S. Naval Medical School, National Naval Medical Center, Bethesda, Maryland.

*Note: The enclosure is not included here because of its length and the fact that a copy of it accompanied a copy of the original letter to all ships and stations.

(Not Restricted)

6. This procedure will not conflict with the pamphlet, "Instruction for the Navy Personnel Accounting System" nor the "Manual of Enlisted Navy Job Classifications."

--BuMed. W. J. C. Agnew.

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Circular Letter 46-108 15 July 1946 (Not Restricted)

To: MedOfsCom, NavHosps (Continental).

Subj: Active Duty Personnel Hospitalized.

1. In connection with final stages of demobilization, information is required as to categories of active duty personnel hospitalized.

2. It is directed that special letter reports be submitted by air mail showing hospital census of active duty naval personnel on 1 August, 1 September, and 1 October 1946, listing the following categories separately:

USNR:

a. officers, male
b. officers, female
c. enlisted, male
d. enlisted, female

USN:

a. officers, male
b. officers, female
c. enlisted, male

--BuMed. Ross T. McIntire.

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